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ABSTRACT

As part of a series of reports designed to support the implementation of Proposition 10: The California Children and Families Act and to provide comprehensive and authoritative information on critical issues concerning young children and families in California, this report examines home visiting as a service delivery strategy for early intervention services. The aim of the report is to assist Proposition 10 commissioners in the planning and policy-setting process by characterizing existing home visiting programs and models commonly used in California, by summarizing the research literature--highlighting key components associated with positive outcomes--and recommending strategies for integrating home visiting programs into the continuum of comprehensive services for young children and their families. The report begins with definitions and descriptions of theoretical frameworks and describes several program models. The report then examines the effectiveness of different types of programs. Funding sources are discussed. Barriers to determining the effectiveness of home visiting programs are examined and recent evaluation results are presented. This section also suggests strategies for strengthening and for evaluating home visiting programs. The report concludes by asserting that with efforts to improve the quality and sustainability of home visiting programs, to integrate home visiting into the broader service-delivery system, and to build knowledge and facilitate its inclusion in community planning, state and local Proposition 10 commissions can achieve wise resource allocation and more creative and innovative home visiting programs for mothers and their young children. The report's ten appendices include descriptions of the theoretical basis of home visiting programs, program characteristics, common home visiting programs in California, fund streams for California home visiting programs, examples of program performance measures, and particular home visiting programs in California. (Contains 50 references.) (KB)

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UCLA Center for Healthier Children, Families and Communities

Building Community Systems for Young Children

Building Community Systems for Young Children is a series of reports designed to support the implementation of Proposition 10: The California Children and Families Act. Each installment is written by a team of experts and provides comprehensive and authoritative information on critical issues concerning young children and families in California.

December 2001

Home Visiting: A Service Strategy to Deliver Proposition 10 Results

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Table of Contents

I. Introduction 1

II Home Visiting Program Models 3

III. Funding Home Visiting Programs 9

IV Evaluation of Programs 11

V. Strategies to Strengthen the Quality of Home Visiting Programs 17

VI. System-Level Strategies 22

VII. Local Best Practices 24

VIII. The Future of Home Visiting 25

IX. References 27

X. Appendix A: The Theoretical Basis of Home Visiting Programs 29

XI. Appendix B: Home Visiting Program Characteristics 30

XII. Appendix C: Common Home Visiting Programs Found in California 33

XIII. Appendix D: Funding Streams for the Home Visiting Programs in California 37

XIV. Appendix E: Federal Funding Sources for Home Visiting Programs 39

XV. Appendix F: Summary of the Packard Foundation Report 41

XVI. Appendix G: Examples of Home Visiting Program Performance Measures 43

XVII. Appendix H: Fresno County's Nurse-Family Partnership Program 44

XVIII. Appendix I: The Hope Street Family Center Home Visiting Program 47

XIX. Appendix J: The Alameda County Commission's Every Child Counts Initiative 50

Home Visiting: A Service Strategy to Deliver Proposition 10 Results

I. Introduction

Home visiting has emerged as an important service-delivery strategy because it potentially affords unique opportunities for reaching psychologically- and geographically-isolated populations, for gaining a more realistic and complete picture of the home environment, and engaging families with young children in a range of services designed to promote the healthy development of children and the well-being of parents.

Home visiting has been a long-standing tradition in many European countries, and has recently re-emerged over the past few decades in the United states as one of the key components in the delivery of comprehensive services for families with young children.[1] Home visiting programs, which under certain conditions have been shown to produce positive impacts on mothers and young children, are also frequently employed as a means to reduce barriers to accessing services, reach psychologically and geographically isolated populations, and to gain a more realistic and complete picture of the home environment. Further, the provision of services in the home helps to ensure that curriculum/interventions are relevant to family circumstances and responsive to individual family needs.

Prenatal and early childhood home visiting has been highlighted by the California Children and Families (Proposition 10) Commission as an important service-delivery strategy and program option for counties to consider as they develop comprehensive systems to support families with young children [2] in part because the goals of many home visiting programs are well matched with the Commission's strategic goals. For instance, home visiting programs have traditionally sought to improve families' knowledge, attitudes, and behaviors regarding parenting, support children's health and development, prevent child abuse and neglect, and facilitate maternal life-course development. These goals of home visiting programs are strongly aligned with the three Proposition 10 strategic results (improved family functioning, child development, and improved child health), and the three focus areas (parent education and support services, child care and early education, and health and wellness). Figure 1 lists the specific recommendations for the use of home visiting as an intervention strategy that appear throughout the California Children and Families Commission Guidelines.

There has been a long history of support for home visiting in both the United States and in Europe by child and family advocates who view home-based services as one of the essential components in the delivery of effective maternal and child health and child welfare services. However, evidence on the effectiveness of home visiting and its impact on short- and long-term outcomes has been inconsistent. As summarized in a recent overview of home visiting research, we still lack clarity as to if, how, and for whom home visiting produces positive outcomes.[3] Lack of clear evidence for short and long-term benefits has created controversy within the field of home visiting as well as concern by those charged with implementing services for young children and their families. Within

this context, State and County Proposition 10 Commissioners are being asked to evaluate local service delivery systems and consider how to utilize home visiting to strengthen the continuum of care for families with young children.

Figure 1. Recommendations Concerning Home Visiting Services as Listed in the California Children and Families Commission Guidelines

In its guidelines, the California Children and Families Commission (Proposition 10) recommends that:

- Pediatric nurse practitioners and family advocates based in community organizations work directly with young parents through a combination of home visiting and center-based approaches;
- Organizations collaborate with or establish home visiting programs for early parent education programs, with emphasis on eliminating prenatal exposure to substance abuse;
- Home-based programs be expanded to educate new parents on child development and family life skills;
- Outreach to parents in their homes occurs particularly for at-risk and isolated families;
- Home visiting be utilized to prevent abuse and neglect, and to improve maternal, infant, and child health;
- Public health nurse (PHN) home visitation programs be established following delivery of newborns; and
- Childhood immunizations be increased by using home visitation strategies.

California Children and Families Commission Guidelines. 1999, California Children and Families Commission: Sacramento

While a number of questions remain about the potential effectiveness of different home visiting programs, this report takes the position that the home visiting "cup" is not half-empty, but half-full. We believe that there is much to be learned and gained by efforts that focus on improving the quality of existing programs. Further, efforts to strengthen program linkages with other services for children and families, especially center-based family resource centers, child care providers, and school programs that offer child-focused services, may foster a more integrated and more demonstrably effective early childhood service-delivery system. To this end, the aim of this report is to assist commissioners in the planning and policy-setting process by characterizing existing home visiting programs and models commonly employed in California, by summarizing the research literature – highlighting key components and practices that have been associated with positive outcomes – and recommending strategies for integrating home visiting programs into the continuum of comprehensive services for young children and their families. Our approach is to use the best evidence available regarding the effectiveness of different home visiting programs, and to consider strategies that will both improve our knowledge base about what works, while simultaneously advancing Proposition 10's goal to build the most effective system of services available for supporting children's health and development. In this report, we begin with a listing of definitions and theoretical frameworks, and then describe a number of program models. We then turn to a review of the evidence about the effectiveness of different types of home visiting programs.

II. Home Visiting Program Models

Definition

Home visiting in itself is not an intervention or a program, but rather a strategy for service delivery from which to launch any number of interventions designed to achieve a wide variety of outcomes. Home visiting programs target different populations within the community via a variety of staffing and practice models, curricula, and intervention approaches. Many home visiting programs target populations and address outcomes distantly related to those of the Commission. For instance, there are home visiting programs that provide home health care to the elderly, address truancy in teenage boys, or offer respite care to family caregivers of the disabled.

This report will focus on home visiting programs for families with young children that are preventive in nature, that begin prenatally or during the early months of life, and are sustained over an extended period during the child's first 5 years. As this report will demonstrate, even within this narrowed definition, programs vary greatly in their target populations, staffing models, and curricula and they encompass a broad range of primary, secondary, and tertiary prevention strategies targeted at health and development, education, and family-support outcomes. In addition, specific interventions taking place in the home often include some combination of the following services: assessments and problem identification, early childhood education, parent education and instruction, counseling and mental health services, health care, advocacy, case management, treatment services, care coordination, and referral assistance.

History

Wasik, in her book *Home Visiting: Procedures for Helping Families*, describes the history of home visiting in the United States and Europe.[4] She outlines the key events and movements in the child health and welfare arena that have influenced the use of home visiting as a strategy to improve the well-being of vulnerable children and their families.

Wasik explains that home visiting has its roots in Europe, and dates back at least to Elizabethan England. At the turn of the twentieth century in England, the public health "nurse and child advocate" Florence Nightingale, through her inspirational writings, was influential in defining the role of nurses and paraprofessionals in preventive health care in the community and establishing nurse training programs for home visiting. For many European countries today, including Belgium, Denmark, France, Germany, Ireland, the Netherlands, Norway, Spain, Switzerland, and the United Kingdom, home visiting is a routine, widely accepted component of a more comprehensive system of care.

European practices for maternal and child care are often described as a model for practice in the United States. However, as Kamerman has described, the lessons from Europe may be complicated because of the fundamental differences between our systems.[5] In contrast to the United States,

many European home visiting programs are universal, are provided to and expected by both rich and poor, and thus are well accepted by the general public. Further, many European countries have broad government-funded health and social services systems and therefore can more easily implement and integrate home visiting programs into a comprehensive delivery infrastructure. Further discussion of the applicability of universal home visiting in the United States is discussed in section V of this report.

Wasik explains that although there were early examples in the United States of nurse, teacher, and social worker home visiting models, home visiting did not truly evolve and become an organized component of public agencies until the beginning of the twentieth century. Nurse home visiting began in the United States in 1893, when two public health nurses, Lillian Wald and Mary Brewster, used home visiting as a means to address the poor health and terrible living environments of Manhattan's Lower East Side residents.[6] Wald and Brewster, who would go on to become significant figures in the emerging field of maternal and child health, were the catalysts for the creation of the first White House Conference on Children (convened in 1909) as well as the establishment of the U.S. Children's Bureau and the Organization of the Child Welfare Leagues of America. With the passage of the Sheppard-Towner Act in 1921, which organized the provision of maternal and child health services, home visiting became part of the federal health infrastructure. The Great Depression also significantly increased the use of nurses to reach poor families in their homes.

Social movements and technological developments in the mid-to-late twentieth century have increased the use of the home as a servicedelivery platform. For instance, since the 1960s, there have been increases in the numbers of medically fragile, pre-term, and high-risk infants cared for in homes, and a trend toward de-institutionalization of care for the disabled and chronically mentally ill.[4] Additionally, increased concerns about the effect of poverty on the cognitive performance of children in the 1960s contributed to the establishment of federal programs such as the national Head Start Program that still today provide early intervention services for poor children, including services in the home.[7]

In the last two decades, the increase in public pressure to both reduce child maltreatment and prevent children from being unnecessarily removed from their homes has renewed the call for statewide and national home visiting programs. In 1991, the U.S. Advisory Board on Child Abuse responded to this crisis by recommending that the federal government begin phasing in a national, universal home visiting program for children during the neonatal period.[8] This recommendation was largely due to promising results from a small number of well-done home visiting studies that indicated that home visiting programs had the potential to decrease the incidence of child abuse and neglect. Although the federal government did not respond positively to these recommendations, state governments, the private sector, and foundations have helped to institute several national and statewide initiatives to increase the availability of home visiting services. For instance, the Ronald McDonald Foundation awarded a $1 million grant to the National Committee for the Prevention of Child Abuse to launch Healthy Families America (HFA), aimed at replicating the Hawaii Healthy Start home visiting

program. [9] [10] HFA, along with other programs commonly found in California, will be discussed later in this section.

During this same period, the field of home visiting research emerged to examine empirically the benefits and limitations of home visiting as a service strategy. In the early 1990s home visiting blossomed as a result of preliminary evidence that well-designed home visiting programs could produce positive outcomes for children.[11] A recent national survey, commissioned by the Commonwealth Fund, found that many states are making substantial commitments to home visiting programs through policy development or direct support. Of the 42 states that responded to the survey, 37 reported state-based home visiting programs, where state-based home visiting programs were defined as those that are guided by state policies and administered by state agencies.[12] Although California was not identified (or did not identify itself) as having a state-based home visiting program, significant funds are allocated toward home visiting in California, and various models of home visiting have been implemented across the state. These models and their funding sources are discussed later in this section and in Appendices C and I.

Certain home visiting models, such as the Nurse Home Visiting Program that began in the 1970s in Elmira, New York, and has evolved into what is currently known as the Nurse-Family Partnership (NFP) program, [13] have continued to show positive results for children and their families, using rigorous experimental designs. Most recently, however, the 1999 issue of *The Future of Children*, published by the David and Lucile Packard Foundation, methodically reviewed evidence about the impact and effectiveness of home visiting,[3] and suggested that the benefits of many programs are less than certain. These findings highlight the need to include program evaluation as an integral part of program implementation and continued funding to both increase knowledge of what contributes to an effective home visiting program, and also to ensure standards of program accountability.

Theoretical Basis for Home Visiting

Before describing the different components of and wide variation in home visiting programs, it is important to outline the theoretical underpinnings that describe how home visiting, as a service strategy, is believed to support human development. Two influential theories that have guided model development for programs such as the Nurse-Family Partnership program, are Bandura's theory of individual self-efficacy and Bronfenbrenner's ecological model of human development. Self-efficacy in the context of home visiting sees the primary role of the home visitor as building confidence and capacity in families to achieve attainable goals. The ecological approach recognizes how family, friends, and community have an important environmental influence on an individual's life, and take these factors into account in constructing a long-term therapeutic plan.[14] In addition, this approach maintains that home visiting programs may be effective by using strategies that are not only directed at the child and family, but also address issues related to the family's relationship in their community.[15]

Many home visiting programs are even more eclectic and combine key principles from various theories about what contributes to positive human development. Some home visiting programs have sought to build upon ecological theories of development by focusing on a relationship-based approach, incorporating attachment and object-relationship theory, including notions of individuation-separation and self-efficacy. [16] Heinicke et al. describe this type of approach as one that focuses on the process whereby a person makes or maintains a positive relationship with another, develops an expectation of mutual satisfaction or trust, and uses that relationship to define and resolve internally and externally focused problems.

Appendix A outlines various other assumptions, perspectives, and theories that programs have commonly incorporated into their home visiting programs. These concepts, based in both research and strong philosophical beliefs, provide the underlying logic for program design and development.

Characteristics of Home Visiting Programs

A home visiting program comprises many dimensions: its program goals, target population, intensity and array of services, average and maximum caseloads, and staff qualifications. Before describing current programs in California, it is important to describe these dimensions or program characteristics and how they differ among programs because certain components of programs have been shown to be associated with improved child and family outcomes. Appendix B organizes the major characteristics of home visiting programs and discusses their variation based on a variety of reports and research efforts, [3] [14] [17] including three home visiting surveys summarized below.

Roberts and Wasik conducted a national survey in 1987 and 1988 of more than 4,000 home visiting programs to obtain information on home visiting for families with children.[1, 17] Of the 1,904 agencies that returned questionnaires, 643 indicated that their home visiting programs focused on children from birth through age 3. Key findings from this survey include:

- Program domains: Thirty-nine percent of the programs were educational, 36% were health-related, 23% were from social service perspectives, and 2% were Head Start programs.
- Service array: More than 80% reported services to enhance child development/parenting skills. From 68% to 75% reported services to strengthen parental coping, provide emotional support, and deliver information and/or diagnostic services.
- Intensity of services: Half of the programs offered home visits on a weekly basis, 12% on a biweekly basis, 15% monthly, and 22% on some other schedule.

A more recent national survey, commissioned by the Commonwealth Fund and published in May 2001, was conducted to assess state policies regarding home visiting through an examination of state-based home visiting programs targeting low-income families with young children.[12] Of the 42 states that responded to the survey, 37 reported state-based home visiting programs. Key findings from this survey include:

- Program domains: The most frequently reported purposes for home visiting were to improve parenting skills (81%), enhance child development (76%), or prevent child maltreatment and neglect (71%). Approximately half of the programs identified maternity/infant outreach, high-risk infant follow-up, early intervention, or altering maternal life course as a main reason for home visits. A smaller proportion (24%) reported that follow-up to early hospital discharge was the primary purpose of the intervention.
- Service array: Most programs (98%) concentrated on offering advice and referrals. Home and family assessments also were reported as a component of a great majority of programs (88%), as was parent education in child development was reported as a service of many programs (86%). Mental health services (as opposed to referrals) were least likely to be delivered by home visitors (24%).
- Intensity of services: Most states reporting said that multiple home visits take place, generally on a routine schedule, but also on an "as needed" basis. A small group of state-based home visiting programs limited home visits to one per family.

In April 2000, the Los Angeles County Department of Health Services developed an inventory of home visiting programs in the county and conducted phase I of the Los Angeles County Home Visiting Survey to track and assess the characteristics of home visiting programs targeting women and young children in the County. [18] The inventory identified 94 organizations operating 194 home visiting programs. Of the 194, phone surveys and self-administered questionnaires were collected from 91 programs. Data were collected on model characteristics, target populations, staff qualifications, program capacity, and evaluation. The Los Angeles County Proposition 10 Commission is working collaboratively with the county to implement phase II of the survey. Key findings from this survey include:

- Program domains: Although most programs appear to be comprehensive, 40% reported that their primary program focus was on safety and survival, while 26% concentrated on school-readiness, 24% on good health, 5% on social and emotional well-being, and 2% on economic well-being (3% were not classified).
- Service array: Over 80% of the programs reported that their home visitors conduct case assessment and case management activities. The most frequently reported educational topics discussed in the home were parenting support and education on child health/development (80%) and home safety (74%).
- Intensity of services: Sixty-six percent reported scheduling weekly home visits, 18% monthly visits, 2% quarterly, and 1% reported conducting annual visits. Thirteen percent reported frequencies of visits that varied over time. Twenty-two percent of respondents provided services for less than 6 months, 40% provided services for 6–12 months, 28% for 12–36 months, 2% for over 36 months, and 8% reported varied durations in services.

In comparing the results of these surveys, it is interesting to note that the earliest survey, conducted by Roberts and Wasik, categorized each program into one of four domains, whereas the two more recent surveys (the national survey commissioned by the Commonwealth Fund and the survey

conducted in Los Angeles County) addressed the extent to which programs focus on multiple domain areas. All three surveys reported that parenting skills and child development were core service components of their home visiting programs. However, the two most recently surveys underscored the striking lack of mental health services provided in the home. Perhaps the most important finding, addressed in both the Roberts and Wasik survey and the Los Angeles County survey, was that home visiting was provided at a relatively intensive level. At least half of the programs reported offering weekly home visits. This finding is encouraging because it is those programs offering more intense services that are thought to have more success in engaging families in their program activities.

Universal vs. Targeted Approach

An important issue when considering how to approach the design and development of home visiting services for a population is whether home visitation should be targeted to high-risk families or be universal and target all children and families. The resolution of this question has enormous cost, design, and service-intensity implications. Some researchers have argued that intensive home visitation should not be considered on a universal basis because research has shown it to be cost-effective only for those families at greatest risk.[3, 13, 19] Analysts have also argued that families who are not low-income, isolated, or lacking important social resources may not need early interventions and, if they do, are likely to access these services on their own.

Advocates for universal home visiting programs [5] [8] argue that the targeted approach stigmatizes the service and prevents families who need it from accepting or staying with services. Further, targeted programs are often not successful in gaining long-term political support. Finally, there is the concern that programs that enroll families using individualized psychosocial risk screening tools may actually misclassify a large portion of families at intake because risk assessment systems are of questionable accuracy. [20] A compromise approach that addresses the issue of stigmatization offers time-limited initial home visits on a universal basis within a given community or geographic area, and then augmented home visiting only to those who have been determined to be at higher risk.[21]

Public Health Nurse Home Visiting Programs

Traditionally, public health nurses (PHNs), through local health departments, have played an important role in maternal and child health by offering some type of universal home visiting services to communities. In a recent examination of the current role of PHN home visiting services, the Public Health Nursing Task Force of the California Nurses Association noted a decline in the role for PHNs in community-based health promotion and disease prevention activities for maternal and child health populations. [22] The decline over the last 10 years is due largely to the restructuring and downsizing of the public health system and the re-direction of funds to the private sector.

The Public Health Nursing Task Force has called for a re-establishment of countywide PHN home visiting services for maternal and child health populations in order to address the issue of stigmatization.[22] They also believe that home visiting, offered universally within a given

community, can strengthen the continuum of services by linking high-risk families to appropriate public- and private-sector services and resources.

Common Models Used in California

Many organizations create their own unique home visiting program models based on agency experience, local best practices, and the needs and input of local community members. Other programs replicate or adapt known statewide or national program models that have shown some degree of success in other locales. Appendix C describes the characteristics of the most commonly employed home visiting programs in California – Adolescent Family Life Program, Black Infant Health, Cal-LEARN, California Safe and Healthy Families, Early Head Start and Head Start Home-Based Option, Early Start, Family Preservation, Healthy Families America, High-Risk Infant Follow-Up, and the Nurse-Family Partnership program. These programs may reflect a standard model or a specific funding source that permits county by county variation in the models implemented.

Family Preservation Programs are frequently excluded from discussions of home visiting because of the mandatory nature of family involvement, the broader age range of the target population, and the traditional focus on brief yet intensive services geared almost exclusively toward preventing children from entering the foster care system. Family Preservation Programs have been included in program descriptions in this report (see Appendix C). However, because there is evidence that some of them are shifting to interventions with longer durations and are offering a more comprehensive and integrated set of support services for families aimed at both the prevention of family problems and the prevention of child placement.[23, 24]. However, this report does not review the extensive literature on effectiveness of family preservation programs.

III. Funding Home Visiting Programs

Local agencies receive funding to operate home visiting programs through a combination of contracts, grants, fees for service, and charitable donations. Appendix D displays the major public funding sources/streams for some of the common home visiting programs in California. The funding agencies listed in that appendix also provide references to a variety of other programs and initiatives and are not restricted to those programs listed in the table. Funding sources for home visiting programs come from: 1) local, state, and federal departments of health, mental health, education, social services, and probation; 2) Medi-Cal and Healthy Families; 3) voter initiatives such as Proposition 10 and Proposition 99; 4) private foundations; 5) non-profit organizations; 6) state litigation such as the Tobacco Settlement; 7) health plans; and 8) individual donors.

Many of the funding streams that are available to home visiting programs are categorical in nature and therefore can create barriers to providing a comprehensive set of integrated services to children and their families. Categorical funding streams target narrowly defined aspects of family life, and

have specific requirements regarding program design, curriculum, staffing, evaluation, and eligible target populations. As a result, home visiting programs often operate programs using a patchwork of categorical funds that try to meet the full range of their clients' needs.

A number of recent publications have been developed to help policymakers and program planners identify, pool, and leverage the various funding sources available for home visiting programs. For instance, Prevent Child Abuse America, which administers the Healthy Families America (HFA) home visiting program model, has developed a variety of publications on financing home visiting programs aimed at reducing child abuse and neglect. Prevent Child Abuse America has four publications available to order on their website (www.healthy familiesamerica.org) that focus on financing issues for home visiting programs. They are 1) *Healthy Families America, Medicaid and the Child Health Insurance Program*; 2) *Federal Funding for Child Abuse and Neglect Prevention: Accessing New Funding Sources*; 3) *State Tobacco Settlement Funds and Child Abuse Prevention Programs*; and 4) *Temporary Assistance for Needy Families and HFA: Accessing a New Funding Source*. HFA's publications provide information on how to access funds from a variety of sources such as Medicaid, State Child Health Insurance Program (SCHIP), State Tobacco Settlements, and the Temporary Assistance for Needy Families (TANF) Program.

The National Center for Children, Families and Communities (NCCFC), in collaboration with Replication & Program Strategies, Inc., compiles an annual guide to federal funding resources for the national implementation of the Nurse-Family Partnership program.[25] The NCCFC guide also provides background on major funding sources such as Medicaid and TANF, as well as Title V – Maternal and Child Health Block Grant, and Title IV – Child Welfare Services. Appendix E includes excerpts from this guide that summarize the key elements of Medicaid and TANF. The guide also outlines how these resources may be used to fund all, or specific, components of the Nurse-Family Partnership model, and describes the experiences of individual sites in securing and administering funds from these sources.

One of the richest sources of information regarding the financing of home visiting programs is The Finance Project, a non-profit organization dedicated to promoting more effective financing of family and children's services. The Finance Project has developed three key publications to aid in the financing of home visiting programs.[26-28] Federal *Funding for Early Childhood Supports and Services: A Guide to Sources and Strategies* by Fisher, Cohen, and Flynn is designed to help policymakers and program managers take advantage of federal funding opportunities.[26] It identifies and summarizes nearly 60 federal programs that have the potential to support home visiting programs. Highlighted among them is a discussion of how Medicaid and Title IV-E funds have been used to support home visiting programs. For example, Fisher et al. discuss how Medicaid can potentially be used to cover the costs of activities such as intensive outreach to ensure that parents are able to access preventive health care or for case management services furnished as part of a stand-alone Medicaid service under the Targeted Case Management Option. Further, if the target population of a home visiting program was comprised of open protective services cases, the report

discusses how the case management and supervision costs of the program could be captured under Title IV-E administrative claiming.

Financing Family Resource Centers: A Guide to Funding Sources and Strategies by Watson and Westheimer describes the characteristics of family resource centers (FRCs), principles and strategies for financing them, and current financing sources.[27] It also discusses potential reforms for improving the financing environment. As FRCs are often funded to administer home visiting programs, many of the resources listed in this guide also apply to home visiting programs operating out of FRCs and other community-based organizations. Watson and Westheimer also provide tools for tracking staff positions such as home visitors that are allocated to different funding sources, and discuss ways to diversify funding by recognizing that a particular service can often be presented in different ways to attract funders with different interests. Watson and Westheimer explain that one of the most striking trends has been the involvement of FRCs as service providers funded by TANF.

The Finance Project's report titled *Financing Early Childhood Initiatives: Making the Most of Proposition 10* by Hayes provides a thorough discussion of financing early childhood development programs as it relates to California's Proposition 10 initiative.[28] This report describes the funding sources for early childhood initiatives, including federal funding streams that support programs for young children and their families. This report also provides a series of case studies that demonstrate that some communities are finding sustainable financial resources for their programs in spite of the limitations imposed on them by categorical funding streams.

IV. Evaluation of Programs

As with many complex intervention strategies, there are a number of barriers to determining and comparing how well home visiting actually works in a community setting. As a result, most of the research that has been conducted on home visiting programs has been based on efficacy studies, and thus there are limited data on the effectiveness of wide-scale program implementation. Research on efficacy shows the degree to which intervention strategies can work under ideal conditions with carefully selected populations and with optimal resources, whereas effectiveness research measures the impact that an intervention achieves in the real world under practical constraints.[29]

Key barriers to determining the effectiveness of home visiting programs include these:

- Because many home visiting programs include a comprehensive curriculum and employ strategies within the home as well as those that are center-based, it is difficult to separate out the effects of each of these components.
- There are limitations to measuring many of the outcomes that home visiting seeks to address. For example, programs may find it difficult to collect accurate information on risky sexual behaviors of their clients or illegal activities such as child abuse or substance abuse.

- Even though some valid and standard measurement tools exist, they are underutilized and not uniformly employed by home visiting programs.

Further, the ability to compare effectiveness across programs is limited by the fact that although these programs often share common goals around the importance of children's early years, they differ dramatically in many other dimensions such as the target population, staffing model, and the mix and intensity of services offered.

In spite of these limitations, the field of research is growing, and there are a number of rigorous empirical studies that provide important information about the effectiveness of home visiting programs. As this section reveals, however, research findings regarding home visiting programs are a source of controversy within the field because studies conducted of various model programs have yielded mixed results and the lack of systematic methods for conducting wide-scale reviews and meta-analysis of programs have led to varied interpretations. (Meta-analysis is a statistical analysis of a collection of studies, especially an analysis in which studies are the primary units of analysis. Meta-analysis methods focus on contrasting and combining results from different studies, in hopes of identifying consistent patterns and sources of disagreement among those results.[30])

Another challenge to assessing the effectiveness of home visiting programs is that most of the research has examined home visiting in isolation from the service-delivery system in which it is functioning; the research has therefore provided little information on how to optimize the impact of the home visiting service component in the context of a broader set of early childhood development and family-support services.

The Packard Foundation Report on Home Visiting

One of the most comprehensive sources of information regarding evaluation results of home visiting programs for young children is the Spring/Summer 1999 issue of *The Future of Children*, published by the David and Lucile Packard Foundation.[31] Six national home visiting program models were chosen for review because they fairly represented the range of different home visiting models used across the country, and they were among the best studied, with evaluations of at least some of their program sites using rigorous randomized trials. A brief description of six programs and a summary of their evaluation findings are found in Appendix F.

Editors Gomby, Culross, and Behrman reviewed the individual program evaluations and, in their article, "Home Visiting: Recent Program Evaluations – Analysis and Recommendations," found the evaluation results to be mixed and, where positive, often modest in magnitude.[3] Their review of the studies revealed some benefits in parenting practices, attitudes, and knowledge, but found that the benefits for children in the areas of health, development, and rates of abuse and neglect were more elusive.

Gomby et al. reported that only one program model, the Nurse-Family Partnership (referred to in 1999 as the Nurse Home Visitation Program), consistently revealed marked benefits in maternal life course. When focused on low-income and unmarried women, the Nurse-Family Partnership (NFP) was found by a RAND Corporation study to produce the largest economic return to government and society of all the major early childhood programs that have been carefully studied to date. [19]

Gomby et al. found that when home visiting programs produced benefits, those benefits were often concentrated among particular subgroups of the families, but there was little consistency in these subgroups, even across sites that implemented the same program model. In most of the studies described, programs struggled to enroll, engage, and retain families. When program benefits were demonstrated, they usually occurred only for a subset of the families originally enrolled in the programs, they rarely were present for all of a program's goals, and the benefits were often quite modest in magnitude. The editors recommended:

- Any new expansions of home visiting programs should be reassessed in light of the findings presented in that issue of the journal..
- Existing programs should focus on efforts to improve the implementation and quality of services.
- Practitioners and policymakers should recognize the inherent limitations in home visiting programs and embrace more modest expectations for their success.
- Home visiting services are best funded as part of a broad set of services for families and young children.

Other Recent Evaluations

A number of other recent reviews provide additional information about the potential limitations and contributions of home visiting programs. The five reviews discussed below overlap somewhat in the studies selected for analysis, and all studies reviewed involved either random or quasi-random assignment of study participants to the intervention and control groups. Four of the five reviews include studies from Canada and/or Europe and thus may not be as relevant to the U.S. population. This is particularly the case where studies are conducted in countries that have nationalized health care systems and offer universal home visiting services to all women.

The first three reviews attempt to quantify the effect size as a means to compare and analyze results across studies.[32-34] They each use a different index/method for calculating the effect size, however, which limits the comparability of the reviews. Haddix et al. [29] explain that in meta-analysis an index of effect is used for measuring study characteristics on a common scale in order to compare and analyze results across studies in terms of the direction and magnitude of effect of a treatment or procedure under study. Typically an overall effect size at a 0.2 level should be considered small; medium effect sizes are at a 0.5 level; and large effect sizes are at a 0.8 level. The meta-analysis by MacLeod et al. used the standard method for calculating the overall effect size. (They subtracted the post-test mean of the comparison group from the post-test mean of the

intervention group and divided the result by the pooled standard deviation.) If means and standard deviations were not reported, effect sizes were calculated from F statistics, chi-squares and t statistics. Kendrick et al. did not attempt to calculate the overall treatment effect because means and standard deviations were not reported by all studies. Instead, separate effects were entered into the meta-analysis using Fisher's method. Hodnett used pooled odds ratios as the overall estimate of effect.

The review by Heinicke and Ponce takes a novel qualitative approach to reviewing a variety of home visiting programs that employ a relation-based intervention between the family and the home visitor to address both process and outcome measures.[35] The final review in this section, by Olds et al., provides an updated analysis of studies of home visiting [36] that have been published since the Olds and Kitzman review in 1993.[11]. Although the updated review covers all major domains analyzed in the 1993 review, this section focuses on three of these domains, as they have not been covered elsewhere in this report.

MacLeod and Nelson conducted a meta-analytic review of 56 programs to determine which types of programs are most successful in the prevention of child physical abuse and neglect and the promotion of family wellness.[32] The review, which covered the period from 1979 to 1998, included prevention programs in the United States and Canada that targeted children up to 12 years of age. Therapy and treatment interventions were excluded as well as those dealing with sexual abuse prevention or treatment. Thirty-two of the programs analyzed were home visiting programs. Effect size of intervention groups as compared with controls were calculated for outcomes such as out-of-home placement rates, direct and proxy measures of child maltreatment, measures of parent attitudes, observations of parent behavior, and measures of the home environment.

In general, the meta-analysis demonstrated that most interventions that aim to promote family wellness and prevent child maltreatment are successful. The mean effect size of 0.41 for all types of programs, when converted to a percentile, indicates that outcomes for the intervention group sample exceed 66% of those in the control/comparison group sample. Social support (reactive) interventions had the largest effect size (0.61, although this was based on only two studies), followed by multi-component (proactive) interventions (0.56), and home visitation (proactive) (0.41). Media (proactive) interventions had the lowest effect size (0.13).

This analysis found that the most successful types of programs tended to be both proactive and to begin prenatally or at birth. Gains made by proactive interventions were sustained and even increased over time. Those gains made through reactive interventions tended to fade more quickly. The home visiting programs that were most successful in preventing child maltreatment were those that lasted more than 6 months, and provided more than 12 home visits. Eckenrode et al., in a 15-year follow-up study of the Elmira, New York Nurse-Family Partnership program, discuss the reasons why some programs may show little impact on child abuse and neglect.[37] They found that the presence of domestic violence may limit the effectiveness of interventions to reduce incidence of child abuse and neglect.

Kendrick et al. conducted a meta-analysis and systematic review on home visiting programs in the United States, Canada, and the United Kingdom to evaluate the effectiveness of home visiting on parenting and quality of the home environment in relation to parenting.[33] To be included in the study, home visiting programs had to include at least one post-natal home visit. Of the 12 studies using the Home Observation for Measurement of the Environment (HOME) assessment tool, the meta-analysis found a highly significant effect of home visiting on parenting and the quality of the home environment. Twenty-one of 27 studies reporting other measures of parenting also found significant treatment effects favoring the home-visited group on a range of parenting measures.

The majority of studies reviewed in Kendrick et al. used professional home visitors, most commonly nurses, but also teachers or social workers. The results of the eight studies that used lay workers appeared similar to the professionally staffed home visitor models with regard to improved parenting skills and the quality of the home environment. Six of the 27 studies failed to show positive results in the intervention groups; however, these studies did not appear to be a distinctive group in terms of the specific characteristics of the programs.

Hodnett and Roberts conducted a systematic review of home-based programs offering social support (including information, advice, and emotional support) for socially disadvantaged mothers to determine program effects on a variety of maternal and child health outcomes.[34] Eleven studies from the United States, Canada, Ireland, and the United Kingdom were included in the analysis. Trials were eligible for inclusion in the review if the study intervention involved social support during one or more postpartum home visits. Overall, the review found that home-based support programs may have benefits for socially disadvantaged mothers and their children. Specifically, the analysis found a trend (albeit non-significant) toward reduced child injury rates. However, the effect of home visitation on the occurrence of child abuse varied across studies in both magnitude and direction. The authors questioned the utility of reporting abuse as an outcome measure because of the potential for surveillance bias that is likely to result in an underestimation of benefits in the home visitation programs as compared with the control groups.

Other findings of the meta-analysis included results on childhood immunizations, hospitalizations, and emergency department visits. In four of the six trials that examined immunization coverage rates, infants of visited mothers were less likely to have incomplete well-child immunizations. All four trials reporting the effect of home-based support on hospital admissions found a lower incidence of hospital admission in the visited group. Five of the six trials reporting the effect of home-based support on the frequency of emergency department visits found that emergency department visits were reduced for home-visited children.

Heinicke and Ponce examined 15 early family intervention studies conducted in the United States in which the relationship between the family and the intervener (the home visitor) was hypothesized to make a significant impact on both the process and outcome of the intervention.[35] *The* studies reviewed were family-focused in that the intervention addressed some aspect of parent, parent-child, and child functioning. All interventions began in pregnancy or in the first six months of life and

involved a sustained relationship for at least a three-month period. Twelve of the 15 studies reviewed were randomized trials.

The authors report that five areas of maternal functioning and maternal support changed as a function of a relation-based early family intervention and were accompanied by parallel change in mother-child functioning. Further, they found that at least three studies showed a positive impact on mother-child interaction. By contrast, child functioning was less consistently influenced in the studies reviewed. Five intervention studies showed a sustained, positive impact on general indices of cognitive functioning, six found no program effects, and four found an initial program effect that was not sustained at follow-up.

Using the conceptual framework and hypotheses developed by the authors for the literature review, Heinicke and Ponce present findings from their randomized trial of the UCLA Family Development Project, a relation-based home visiting/mother-infant support group intervention. They report that, by the first year of the child's life, the intervention made a significant impact on partner and family-support measures, and on three social-emotional mother-infant transactions. [16] By 2 years of age, the project demonstrated a positive impact on two indices of the mother's support and on five areas of mother-child and child development [38]

Olds et al. provide an updated analysis using 15 scientifically controlled home visiting studies conducted in the United States and Europe [36] published since the Olds and Kitzman review in 1993.[11] The authors re-examined their 1993 recommendations in major domains of maternal and child health and well-being in light of the recent studies.

Olds et al. conclude that there are some populations of children with illnesses or vulnerabilities that appear to benefit from some well-designed and well-conducted home visiting programs, and that the success of such programs was due to the fact that the parents had a heightened sense of vulnerability and motivation to make use of the visitors' services. But as a means of preventing child abuse and neglect, injuries to children, behavioral problems, and welfare dependence among families at social and economic risk, the authors assert that many home visiting programs have not met expectations. They state that aside from the Nurse-Family Partnership program and a few other programs that are well-articulated and that employ professional visitors, most home visiting programs have failed to affect these outcomes. The Nurse-Family Partnership has produced consistent effects in these outcome domains in more than one trial. Olds et al. recommend that the other programs that have affected these outcomes must be considered experimental until they have been successfully replicated.

Olds et al. explain that the limited or questionable effects of most home visiting programs are likely a result of the lack of carefully conducted programs of research and clinical work that are designed to lead up to testing interventions in randomized controlled trials. When such a program of research is not conducted before home visiting programs are subjected to rigorous testing, studies are done prematurely and often give false impressions that the investment in such programs is a waste of

resources. The last section of this report summarizes the authors' recommendations on how program planners and policymakers can improve the design of home visiting programs to strengthen the program quality and to help certain programs prepare for selected testing of interventions in randomized controlled trials.

Summary of Evaluations

There are notable differences in the level of optimism expressed by the authors in this section about the potential for home visitation programs to improve outcomes for young children and their families. The Packard Foundation report takes the most conservative and cautious approach to the field of home visitation. It advises that expansions of home visiting programs be reassessed in light of the report's findings, and it urges that emphasis be placed on improving the quality of existing services and strengthening the integration of home visiting as a service strategy into the continuum of services for families.

MacLeod, Kendrick, Hodnett, et al. present a more optimistic, yet perhaps less rigorous review of home visiting. These authors, however, acknowledge the problems of publication bias that tend to overestimate the positive effects in meta-analyses. Although Heinicke and Ponce caution that measures used in the studies they reviewed were not always comparable across studies and that they made inferences regarding which findings were relevant to a particular domain, they conclude that, overall, relation-based early family intervention is effective in bringing about changes in the family system. Rather than being contradictory, these four reviews reflect the complexity and limitations of the field of evaluation research, not only for home visiting programs but for many other different types of intervention strategies that ambitiously attempt to address the myriad of issues affecting vulnerable young children and their families.

V. Strategies to Strengthen the Quality of Home Visiting Programs

The next two sections recommend strategies that Proposition 10 commissions can employ to improve the quality of home visiting programs, to maximize their effectiveness through linkages with community-based organizations, and to work with state and local governments and key funding agencies to facilitate a more coordinated and coherent funding strategy for home visiting programs. Wherever possible, these recommendations are drawn from the "gold standard": randomized controlled trials. However, since much of the knowledge in the field of home visiting has not been tested empirically, recommendations are also drawn from program evaluation and documented local best practices established by experienced home visiting professionals in the field.

Improving the Design of Home Visiting Programs

Olds et al. emphasize three essential principles that should be addressed in designing home visiting program interventions for young children and their families.[36] First, home visiting program

interventions should be grounded in epidemiology and developmental research to help identify the adverse outcomes a program seeks to address and to understand the modifiable risks and protective factors associated with these outcomes. Accurately identifying adverse outcomes and modifiable risks in a community helps to ensure that home visitors properly target their efforts. Second, even program interventions that are grounded in epidemiology will have difficulty changing deleterious client behaviors in the absence of a theoretical foundation. To address the challenges associated with changing client behavior, program interventions should employ a theory of behavior change such as self-efficacy theory or attachment and object relationship theory. Third, home visiting programs are much more likely to be effective if they are perceived as relevant and needed by the community being served. New interventions or existing interventions being employed in new communities should be pilot-tested before large-scale program expansion occurs. State and local Proposition 10 commissions can design their grant-giving initiatives to encourage home visiting agencies to adhere to these three overarching principles of program design.

Below is a list of additional factors that Proposition 10 commissions may wish to consider when developing Requests for Proposals (RFPs) for home visiting programs and evaluating potential grantees.

Well-Defined Program Protocol and Curriculum

Effective home visiting programs demonstrate that they have a well-defined and documented program protocol and curriculum that allows flexibility to individualize activities to respond to specific client needs or family crisis. Programs should assess their overall fidelity to the program model as well as track individual staff adherence to the curriculum in order to assess appropriate individualization and inappropriate departures from program protocols.

Intensity of Services

The intensity of services should be considered in light of program goals and family needs. No studies have determined the optimal frequency and duration of program services, but some researchers suggest that at least four visits or at least 3 to 6 months of service are needed before families can benefit.[3] This is an important issue because if program services are not offered frequently enough, families may not engage in the activities. Low family engagement and high attrition can severely affect a program's effectiveness.

Staff Issues

Qualifications – It has been suggested that a home visiting program is only as good as the people who administer and staff it. Staff qualities are what draw participants in and keep them involved. Decisions about the educational, professional, and personal qualifications and standards are pivotal and dependent on each individual program's target population and goals. Although research has not

yet delineated the best qualifications of staff, Gomby et al. recommended that home visitors be extremely well trained and should have at least a high school diploma.[3]

Professional versus paraprofessional - A key consideration for designing home visiting programs is whether to utilize professional or paraprofessional staff as home visitors. Typically, professional home visitors are defined as those who have earned credentials in a relevant field, such as education, nursing, or social work.[4] Under this definition, it is possible for paraprofessional home visitors to also hold advanced educational credentials; however, these degrees would be in fields other than those that relate directly to the field of home visiting. Paraprofessional home visitors are usually from the same community where a home visiting program is delivered and often share the same racial or cultural background of the clients.

Program directors should make the decision regarding whether to hire professional or paraprofessional home visitors based on the goals, knowledge, and skills that the home visitors will need to implement the program successfully. There is significant literature on the potential strengths and weaknesses of both professional and paraprofessional home visitor staff. [9] [39-42] Professionals with clinical expertise can address the specific health, developmental, and counseling needs of families with knowledge and objectivity. Paraprofessionals, who are often hired from the community where home visiting services are provided, may share similar experiences and cultural beliefs with clients, and often have knowledge of and involvement in community networks that can help to quickly gain families' trust. In spite of these important observations, little empirical research has been conducted in this area. Olds et al. have presented results from a Denver trial of the Nurse-Family Partnership that suggest that when comparing nurses and paraprofessionals in the NFP model, paraprofessional staff produce positive effects that fall (in magnitude) between those of the professional nurses and the control group. [42]

One recommended staffing strategy that addresses the needs of families with varying risk levels is to employ both paraprofessionals and a team of multi-disciplinary professional home visitor staff. Although it is important to have only one primary home visitor who can build rapport and continuity with a family, establishing multi-disciplinary teams can bring the full resources of a program to families through case consultation and team supervision.[17] Single-discipline home visiting programs, such as those staffed only by nurses, can establish agreements with other programs to access consultants from other disciplines. Entering into formal partnerships with family resource centers to share resources, facilities, and co-house staff is an effective strategy whereby home visiting programs can offer their staff access to a variety of expertise and a comprehensive set of services to families. An example of such an approach was developed for Hope Street Family Center (see Appendix I).

Training and supervision are critical for achieving and maintaining quality in home visiting services. Resources should be allocated within a program's budget to assure that the home visitors can receive training and supervision from qualified individuals.[39] Home visitors need regular, formal and reflective supervision to provide them a safe time and place in which they can candidly discuss the

families with whom they are working from both objective and subjective points of view.[43] They also need to receive non-judgmental and supportive feedback about their work. Emphasis on supervision for home visitors is particularly important because home visitors work in isolation during much of the day. It is therefore critical to provide supervision that helps them deal with the emotional stresses of working closely and over long periods of time with high-need families, and it helps them maintain objectivity, prevent drift from program protocols, and provide opportunity for reflection and professional growth.[3]

Program Evaluation

Ongoing program evaluation of home visiting programs is essential to track the outcomes experienced by clients in a project and determining if the program is being implemented as intended, if staff are meeting their objectives, and where program improvements are needed. Sufficient funds for program evaluation should be allocated during the program design phase of a project. Although each program collects data with which to assess the success of its unique goals and corresponding intervention strategies, communitywide evaluations and comparisons are facilitated by the use of standard measurement tools that have been tested and proven reliable and valid. A comprehensive list of measurement tools used in recent program evaluations is found in the 1999 home visiting issue of *The Future of Children.* [44]

Proposition 10 commissions can play an important role in building an evaluation infrastructure among home visiting programs by establishing standardized evaluation guidelines and providing training on the use of evaluation models, measurement tools, and data collection and submission procedures. One recommended model for evaluating programs that is gaining momentum among Proposition 10 commissions and county health departments is the Result-Based Accountability (RBA) framework developed by the Fiscal Policies Study Institute.[45]

RBA measures a home visiting program's success in terms of current performance in relation to past performance (using historical project data), and compares project trends to what is expected to occur in the absence of the project (using population statistics and relevant comparison group data where available). Where programs aim to change client knowledge and behavior, program evaluations should be designed to collect these performance measures and make use of pre-test/pos-test evaluation methods to assess the potential extent of these changes.

One key step for home visiting programs employing RBA is to work with clients, line staff, administration, and the community to identify and track the project's performance measures. As displayed in Figure 2, performance measures are conceptualized in a four-quadrant diagram to assess the quantity and quality of an agency's service inputs (often referred to as process measures), as well as the effect or outcomes for the clients in the project (also known as impact measures). Appendix G provides an example of the four-quadrant approach to performance measures as it might apply to a home visiting program. RBA recognizes that many conditions of well being are influenced by factors

that cannot always be changed quickly, and it defines success as turning away from the current trend, rather than turning on a dime to achieve an arbitrary target.

Figure 2: A Four-Quadrant Approach to Performance Measurement

	QUANTITY	QUALITY
INPUT/EFFORT	I. How Much Service Did We Deliver?	II. How Well Did We Deliver Service?
OUTPUT/EFFECT	III. How Much Change/ Effect Did We Produce?	IV. What Quality of Change/Effect Did We Produce?

Friedman, M., *Results-Based Accountability*. 1999, Fiscal Studies Policy Institute.

One important area that affects a home visiting program's success is the level of engagement that families have in the program. Many home visiting programs struggle to enroll, involve, and retain families in home visiting services, and although to some degree family engagement may be beyond the control of individual programs, it may also reflect the design of the program intervention. To assess family engagement in a program, we recommend collecting data on the following three measures: 1) percent of families invited to enroll in the home visiting program that choose not to enroll; 2) ratio of expected versus completed home visits; and 3) percent of clients that leave the home visiting program before it the service was scheduled to end.

Continuous Quality Improvement

One important component to successful home visiting services is a Continuous Quality Improvement (CQI) program that adheres to the principle that programs need not regard current performance limits as inevitable and that program improvements can be made if efforts are focused on changing systems rather than individuals. CQI typically uses management information systems, performance measure data, and staff and client feedback to systematically review overall program operations and the status of each client's case. Where problems or inadequacy in the program process are identified, CQI ensures that targeted quality improvement steps can be implemented. Employing CQI activities can help to ensure that home visiting services are implemented with fidelity to the model and are responsive to the needs of clients.

The effectiveness of a CQI program can be limited by factors such as lack of supportive leadership, lack of involvement of all stakeholders, difficulty in defining the outcomes to be measured, inadequate data collection, resistance of staff, and conflicting time demands for team members. These factors limit a program's ability to implement program improvements quickly. One CQI model that has been shown to effect rapid change is known as the "Model for Improvement" developed by the Institute of Health Care Improvement as part of their Breakthrough Series. [46]

This collaborative model is a method for teaching multi-disciplinary teams to identify their own problem areas, conduct a series of rapid-cycle tests to assess possible changes, and to implement program improvements. Programs or a group of programs that are providing home visiting services can join together, identify change concepts, and work in collaboration toward implementing new approaches, learning from this process, and adapting interventions based on what is learned.

The effectiveness of this technique was demonstrated in a 1996 Breakthrough Series that was a collaborative effort to reduce adverse drug events (injuries related to the use or nonuse of medications) in hospitals nationally.[47] Over a period of 15 months, 40 health care organizations worked collaboratively to test various quality improvement strategies. Eight types of improvement strategies, referred to as "key change concepts," were implemented by seven or more hospitals with a success rate of 70%. This model has great potential for adaptation by home visiting programs particularly because it emphasizes practical program improvements, and does not require lengthy data collection before change can occur.

VI. System-Level Strategies

Integration of Home Visiting Programs into the Comprehensive Service Array

Like any other part of the service-delivery system for young children, home-visiting programs cannot operate in isolation. The needs of families are complex, and no one program, intervention, or strategy is a panacea. Although a home visiting program does not have to provide comprehensive services, consideration should be given to integrating home visiting with a broader set of early intervention and family-support programs from the health, education, developmental, and social services. Integration involves establishing mechanisms for home visiting programs to share information, coordinate activities, implement collaborative initiatives, and facilitate inter-program referral procedures.

Linkages with center-based services that specialize in child-focused developmental activities are particularly important to improving children's developmental outcomes in light of the research that indicates that there has been limited success with these outcomes when home visitation programs are administered without a child-focused center-based component.[3] Some of this may be related to the fact that most home visiting programs try to benefit children indirectly through changes in parents' behavior, rather than directly through interventions with the children. Even those home visiting programs that focus on developmental outcomes by direct activities with the child may not spend the amount of time necessary to show a positive impact in this area. Clearly, a center-based program in which children participate for many hours each week has much more direct contact with children.

Further, embedding home visiting programs in comprehensive family resource centers is believed to improve program effectiveness on a variety of other levels. [14] For the home visitors, having a program that is integrated with the activities of a family resource center helps to increase

opportunities to consult with multidisciplinary staff. For the clients, combining home visiting with center-based activities helps to reinforce the educational efforts of both program components. For the parents, combining home visiting with a center-based component can help to reduce social isolation and can introduce them to additional resource staff. Combined, these factors may help to increase family engagement in home visiting programs and reduce family attrition.

Linkages with the health care sector, including private-practice pediatricians, and obstetricians, community clinics, hospitals, and health plans are also critical. While home visitors can be health care advocates and improve access to care [48], health care providers can serve as a platform from which to identify and refer high-risk clients to local home visiting programs. Home visiting programs can increase the effectiveness of the health care sector by providing supplemental family-support services that are often prohibited by managed care or providers' budgetary reductions.[48]

Coordinated Funding

A number of financing strategies have been recommended to strengthen the short- and long-term value of the tobacco tax revenue and to help address some of the limitations imposed by categorical funding. In *Financing Early Childhood Initiatives: Making the Most of Proposition 10,* Hayes recommends:

- Making better use of resources already being expended on young children and the families through pooled funding streams that combine dollars from several sources and then redistribute resources through a collaborative representative process. Pooled dollars can often be used to fund activities that normally cannot be funded directly form most categorical funding streams, such as collaborative communitywide planning and data collection efforts, and technical-assistance initiatives.
- Using Proposition 10 dollars to leverage federal and state matching funds for early childhood programs.
- Assisting communities to coordinate local strategies for aligning categorical funding from a number of agencies and funding streams to support a comprehensive set of integrated services for children and families.

Using the financing resources such as those referenced in this report, state and local Proposition 10 commissions might consider developing recommendations for enacting the administrative and regulatory changes needed in California to facilitate a more coordinated and coherent funding strategy for home visiting programs. This might include an analysis of how Medi-Cal funds could potentially be used to support home visiting for eligible children and families. As of August 2000, the NCCFC had documented at least 13 states and communities that are tapping into Medicaid to fund all or part of their nurse home visiting program,[25] and many regard this as a largely untapped resource in California for home visiting. If these issues could be addressed in a more systematic way, home visiting programs could better meet the full range of families' needs.

Technical Assistance for Home Visiting Programs

Proposition 10 commissions can help to form county and statewide technical assistance organizations for home visiting programs and family resource centers that focus on improving the quality of programs, strengthening the continuum of services for young children and their families, and maximizing resources and minimizing fragmentation and duplication of effort. Technical-assistance organizations can bring local home visiting program staff together with other key community service providers and stakeholder to:

- Share information, coordinate activities, and implement collaborative initiatives;
- Develop clearly defined roles and responsibilities among service providers;
- Establish inter-agency referral procedures;
- Host comprehensive communitywide, multi-disciplinary staff training and in-service programs that give home visitors the opportunity to refresh and expand their skills;
- Conduct communitywide needs assessments and assets mapping that can be used by funders and program planners to develop strategic plans as they relate to home visiting programs;
- Institute accrediting programs to help ensure accountability, uniformity, and quality of programs;
- Develop standard mechanisms to evaluate and analyze home visiting programs; and
- Create research networks to collect and disseminate the most up-to-date information regarding what has been shown effective in the field.

VII. Local Best Practices

Appendices H-J describe local best practices that exemplify the recommendations in this report. First, Fresno County describes its implementation of the Nurse-Family Partnership Program model (Appendix H). This program is an example of an expansion of a program model that has been proven effective for a variety of maternal and child outcomes. Currently, this model is being implemented in nine California counties. The second best practice highlighted in this report is the Hope Street Family Center in Los Angeles County (Appendix I), where home visiting is one component of a comprehensive set of services that are offered out of a community-based family resource center. The third is a summary of an ambitious relation-based home visiting program funded by the Alameda County Children and Families Commission (Appendix J) that aims to phase in a universal home visiting component for all newborns and a targeted component for medically and socially fragile mothers and their infants.

VIII. The Future of Home Visiting

Home visiting, as a service-delivery strategy, will continue to have the unique ability to reach psychologically and geographically isolated populations, and to gain a more realistic and complete picture of the home environment and the nature of family relationships and circumstances.

This report has outlined the key areas where state and local Proposition 10 commissions can play an important role in the provision of effective home visiting services for young children and their families. We conclude that the future for home visiting is promising if policies encourage the following:

- Program expansions of those models that have been proven effective empirically. In spite of the barriers and limitations to randomized controlled studies, the field of research is growing and there are a number of well-tested home visiting programs that may warrant replication.
- Piloting innovative new home visiting programs that are grounded in epidemiology and developmental research, have a strong theoretical foundation, and are perceived as relevant and needed by the community being served. These programs should have well-defined and documented program protocols, and effectively address issues related to program intensity, staff qualifications, training and supervision, program evaluation, and continuous quality control.
- Linkages with a broader set of early intervention and family-support programs from the health, education, developmental, and social services. In particular, strong linkages can be created by embedding home visiting programs in family resource centers that specialize in child-focused developmental activities.
- Coordinated, sustainable, and flexible funding sources for home visiting programs. Pooled funding strategies can make better use of resources already being expended to provide more comprehensive and cohesive services.
- Collaboration through technical assistance organizations. The creation of such organizations could foster the sharing of key information in the field of home visiting, coordinated training and research activities, and serve as key forums for developing strategic plans as they relate to home visiting programs.

Finally, state and local commissions may want to consider playing an important role in increasing what is known about the effectiveness of home visiting programs. Such an effort is critical in light of the plethora of unanswered questions relating to home visiting programs. Following are some of the key research questions.

- Which home visiting models produce positive outcomes for their clients?
- How intensive must home visiting programs be in frequency and duration to make a significant positive impact on families?
- Can a paraprofessional be as effective as a professional home visitor, and in what setting?

- Can outreach efforts and intervention strategies that are specifically designed for fathers improve outcomes for children in home visiting programs?
- How can policymakers optimize the impact of the home visiting service component in the context of a broader set of early childhood development and family-support services?
- What potential synergies can be obtained by strategically linking home visiting services with other comprehensive strategies and services for young children and their families?
- How do community factors such as the availability of services and the political and economic environment influence the impact of home visiting programs?

Proposition 10 commissions could develop policies and funding streams geared toward a strategic program of research and clinical work designed to lead up to selective testing of interventions in randomized controlled trials.[36] Such an initiative should include pilot testing home visiting models that are grounded in epidemiology and the theory of behavior change, and appear to be well received in the community, and conducting small-scale trials before any full-blown randomized trials.

In conclusion, with efforts in place to improve the quality and sustainability of home visiting programs, to integrate home visiting into the broader service-delivery system, and to build knowledge and facilitate its inclusion in community planning, state and local Proposition 10 commissions can achieve wise resource allocations and ever more creative and innovative home visiting programs for mothers and their young children.

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X. Appendix A: The Theoretical Basis for Home Visiting Programs

Theory	Assumption
Psychodynamic Tradition	Assumes that the best way to effect change is through the quality of the relationship between the home visitor and the parent. The primary goal of the home visitor is to be emotionally available and responsive to the mother.[17]
Parent Education Tradition	Suggests that it is the parent's access to expert information about child development that is the key to improving the competence of parents.[17]
Empowerment Theory	Defines the role of the home visitor as a facilitator or one who assists families to address problems in their lives and formulate and achieve realistic goals.[4]
Family Systems Theory	Recognizes the interdependence of family members and considers their interrelationships when designing interventions.[4]
Social Exchange Theory	Suggests that people will recognize the benefits and costs of certain behaviors through their interactions with others. To motivate parents to accept and engage in home visits, practitioners of this model create a set of expectations to be accomplished during the home visits.[49]
Parallel Process	Describes the ways in which experiences in one relationship carry over into other relationships. By providing the parent with structure, support, and a corrective emotional developmental experience, the family-support staff strengthen the parent's ability to bond with the child and to provide him/her with structure, security, and age-appropriate nurturing.[14]

A variety of other theories have also served as the basis for program development including: Attachment and Object Relations Theory, Life Cycle/Development Theory, Crisis Theory, Psychosocial Rehabilitation Theory, Efficacy Theory, and Learned Helplessness Theory.[14]

XI. Appendix B: Home Visiting Program Characteristics

Program Dimension	Program Variation
Desired Results	• Improve and optimize child health, child development, school readiness and family functioning; • Prevent and reduce family violence and substance abuse; • Identify and treat children with special health care needs, developmental delays, or disabilities; and/or • Improve maternal life-course development (improved economic and educational outcomes, reduced subsequent pregnancies).
Context of Home Visiting Services	• Home visiting may be the primary strategy employed to achieve the organization's mission; or • It may be an adjunct support to other primary activities that are office-, school-, or center-based; and/or • A home visiting program may be linked to other entities providing comprehensive services through a family resource center or within a community collaborative. • The national survey commissioned by the Commonwealth Fund found that many state-based home visiting programs are part of a larger initiative. Nearly half of the programs were part of a larger maternal and child health initiative, 40% were linked to a comprehensive or integrated service initiative, and 38%were a component of a family resource center initiative.
Prevention vs. Intervention	• The continuum of home visitation interventions includes strategies geared toward the promotion and protection of wellness for all or a broad set of the population as well as interventions to ameliorate established problems in identified subsets of the population.
Voluntary vs. Mandatory	• Most home visiting programs are completely voluntary. (There are no negative repercussions if the parent refuses to participate). • Mandatory programs are those employed by protective agencies (child protective services, probation, etc.). They are used with families who have family problems related to child abuse or neglect requiring legal, court monitoring/intervention. Home visiting programs that work with the child in his or her biological home to prevent removal to foster placement or to reunify families that have been separated after an abusive or neglectful situation, are categorized as family preservation programs [50]. • The Los Angeles survey found that 65% of programs in the county are voluntary, 22% are mandatory, and 13% claim to be a mixture of both.
Target Populations and Enrollment Strategies	• *Geographically based*: Families with young children in a specific zip code, neighborhood, or other geographically identified area. • *Demographically focused:* Families with young children who are targeted for enrollment based on maternal age (for instance, teen mothers), or economic, educational, employment, marital, racial/ethnic status, etc. • *Stage of family's life cycle:* First-time mothers, pregnant women, infants and toddlers, children under 5, grandmothers caring for relatives (e.g., kinship care). • *Individually screened and enrolled based on health and/or psychosocial risk factors.* Families where there has been a preterm birth, a neonatal intensive care unit

Program Dimension	Program Variation
	(NICU) graduate, medically fragile children and infants, or where there is evidence from either parent of substance abuse, mental illness, history of incarceration, or unwanted pregnancy.[20]
Intensity of Home Visits	• *Onset*: Home visiting services may be initiated at various stages of the family life cycle or due to identified problems. For instance, health care providers or WIC agencies may refer mothers prenatally or at the birth of their children to home visiting programs. Child protective services may refer families to a family preservation program after a reported incidence of child abuse. • *Frequency* of home visits varies greatly but has been typically offered weekly or monthly. In some programs, frequency is predetermined according to a prescribed visiting pattern. In other programs, visiting schedules are individualized. The Los Angeles survey found that 66% of home visiting programs provide visits to at least some of their clients at least once per week, 18% provided visits on a monthly basis, only 2% limited visits to a quarterly basis, and 1% reported conducting annual visits. Thirteen percent reported varied frequency of home visits. • *Duration*: The national survey by Roberts and Wasik found that a typical home visit usually lasted between 30 to 90 minutes, and that visits conducted by programs focused on child abuse tended to last longer. • *Period of time services are offered*: Home visiting services may be offered for several months or years or for a brief period of time, as part of an initial assessment process, for a particular family crisis, or during a key stage for parent education (i.e. during the newborn period). The Los Angeles survey found that 13% of respondents provided services for less than 3 months. Nine percent provided services for a duration between 3–6 months, 40% for 6–12 months, 28% for 12–36 months, 2% for over 36 months, and 8% reported varied durations in services.[18] This is consistent with the national survey by Roberts and Wasik that found half of the home visiting programs to visit homes for 6 months to 2 years. • The intensity of home visits (in terms of frequency, duration and period of services offered) varies in relation to the caseload size, the level of risk and family engagement, the intensity of the curriculum and the availability of resources.
Caseloads	• Caseloads can range from 5 to 65 families per home visitor; and • Caseloads vary widely as a function of case complexity, curriculum program goals, and funding levels.
Service Array	• Services/activities provided in the home include: • Case assessments and diagnostic screenings; • Early childhood education; • Parent education; • Health care interventions and physical therapy; • Case management/coordination of services; • Psychological support and counseling; and • Referrals and linkage as appropriate to health, education, family-support, and social services. • Focus areas for the home visiting activities listed above include: child health, child development, school readiness, maternal life-course development (improved economic and educational outcomes, reduced subsequent pregnancies), family violence, family functioning, and substance abuse.

Program Dimension	Program Variation
	• The national survey conducted by Roberts and Wasik found that most programs deliver a variety of services. More than 80% reported services to enhance child development and or parenting skills and from 68% to 75% reported that they deliver services to strengthen parental coping, provide emotional support to families, deliver information and/or conduct diagnostic services. The services that were rarely offered included job training, home maker, or respite care services. • The Los Angeles survey found that over 80% of the home visiting programs offered case assessment and case management services. Only 3% provided physical therapy, 4% occupational therapy, and 8% provided respite care. The most frequently reported educational topics were parenting support and education on child health/development (80%), home safety (74%), child abuse prevention (62%), substance abuse prevention (36%), and school readiness (36%). [17]
Staff Qualifications	• Staff qualifications are comprised of home visitors' educational background, work experience, and on-the-job training; • Programs utilize a variety of staffing models including: • Professional vs. paraprofessional; • Combination of professional and paraprofessional; and • Single discipline (e.g. nurse home visitor) vs. multi disciplinary team • The national survey by Roberts and Wasik found that 76% of the programs employed at least some paraprofessionals and 54% required home visitors to have a bachelor's degree.

XII. Appendix C: Common Home Visiting Programs Found in California

Name of Home Visiting Program and Desired Outcomes	Target Population: Voluntary vs. Mandatory	Intensity of Services and Caseload (Intended not actual)	Staff Qualifications
Adolescent Family Life Program (AFLP) • Help pregnant and parenting teens have healthy babies • Prevent subsequent pregnancies to teenage girls • Help teen parents graduate from high school Forty-seven AFLP programs operate in 42 California counties. www.dhs.ca.gov/pcfh/mchb/adolescent.htm	• Pregnant or parenting teens • For females up to age 20 years • For males up to 21 years. Males must be actively involved in caring for the child • Voluntary enrollment	• Generally starts prenatally • Visits occur approximately once per month • Services provided for a period of 1 to 3 years • Caseload - 40 families	Varies: Educators Social Workers Case Managers
Black Infant Health Program • Reduce disparities in rate of African American infant deaths and the rate of low-birthweight infants • Reduce mother's use of tobacco and alcohol • Reduce the incidence of Sudden Infant Death Syndrome (SIDS) BIH operates in 14 counties and two cities where 97 percent of African-American births occur in California. www.dhs.ca.gov/pcfh/mchb/Black_infant.htm	• African American pregnant and parenting women and their infants • Voluntary enrollment	• Generally starts prenatally • Visits occur up to once per month • Services provided for a period of 1 to 3 years • Caseload varies between 25 and 75 families	Paraprofessionals Community Health and Outreach Workers

Name of Home Visiting Program and Desired Outcomes	Target Population: Voluntary vs. Mandatory	Intensity of Services and Caseload (intended not actual)	Staff Qualifications
Cal-Learn Program • Reduce welfare dependency • Assist teens on CalWORKs to stay in or return to school • Enhance parenting skills • Improve child health and development www.dss.cahwnet.gov/getser/callearn.html	• Teens under 19 years old on CalWORKs who are pregnant or parenting and have not yet completed high school • Mandatory enrollment	• Generally starts prenatally • Visits occur approximately once per month • Services provided until teen receives high school diploma/equivalent or turns 20 years old • Caseload – 40 families	Bachelor's Degree in social work, psychology, and child development or a related field
California Safe and Healthy Families (Cal-SAHF) • Prevent/reduce welfare dependency • Reduce avoidable hospitalization and medical costs • Reduce interventions by child welfare, law enforcement, and the courts • Prevent adverse outcomes for children and families (health, development education, substance abuse) • Promote positive parenting • Enhance autonomy and self-sufficiency There are 19 pilot programs in California. www.childsworld.org/welfare/homvis.htm	• Overburdened families defined variably by local programs using demographic characteristics or risk assessment checklists • Voluntary enrollment	• Generally starts prenatally. • Visits occur up to once per week fading to quarterly as needed • Services provided for a period of up to 3 years • Caseload: 25 families	Multi-disciplinary teams that may consist of professionals and paraprofessionals with varying specialties from health, education, and social services.

Name of Home Visiting Program and Desired Outcomes	Target Population: Voluntary vs. Mandatory	Intensity of Services and Caseload (intended not actual)	Staff Qualifications
Early Head Start • Promote healthy prenatal outcomes for pregnant women • Enhance the development of very young children • Promote healthy family functioning • Enhance parenting skills • Optimize child health Approximately 42 grantees operate in California. www.ehsnrc.org	• Low-income families with infants, toddlers ages 0-3 years, and pregnant women • Voluntary enrollment	• Visits occur weekly • Service provided through age 3 • Caseload: 10-12 families	• Minimum standard is an Associate Degree in early childhood education.
Early Start • Promote healthy prenatal outcomes • Improve physical and emotional development • Promote healthy family functioning • Optimize child health www.dds.ca.gov/EarlyStart/main/prev004.cfm	• Families of infants and toddlers from birth up to 36 months with developmental delays and disabilities • Voluntary enrollment	• Visits provided quarterly • Caseload: Approximately 60 families	Bachelors Degree with a focus in early childhood development
Family Preservation • Child safety • Avoidance of out-of-home placement • Early family reunification • Family functioning and stability The program operates in 56 counties in California. www.childsworld.org/welfare/fampres.htm	• Families with children ages 0-18 years under supervision by local child protective services • Mandatory enrollment (parents' custody of child may be based on participation in program)	• Visits occur between 1-4 times per week • Services provided for 6-12 months • Caseloads vary ranging between 5-15 families, depending on acuity	Minimum of a Bachelor's Degree in social work, psychology, or related field

Name of Home Visiting Program and Desired Outcomes	Target Population: Voluntary vs. Mandatory	Intensity of Services and Caseload (intended not actual)	Staff Qualifications
Head Start Home-Based Option • Improve child development • Improve the parents' teaching interaction and problem-solving skills There are approximately 168 grantees in California. It is not known how many have opted for the home-based component. www2.acf.dhhs.gov/programs/hsb/	• Low-income children ages 3-5 years • Voluntary enrollment	• Visits occur weekly • Services provided for a minimum of 2 years • Caseload: 10-12 families	• Associate Degree in early childhood education is minimum requirement
Healthy Families America • Promote positive parenting • Prevent child abuse and neglect www.healthyfamiliesamerica.org	• Family identified as at risk for child abuse, either prenatally or at delivery • Voluntary enrollment	• Visits occur weekly, fading to quarterly • Services provided starting prenatal through age five • Caseload: 25 families	Paraprofessionals and those with bachelor's degrees
High-Risk Infant Follow-up Program • Optimize development • Promote child health • Strengthen parenting skills www.dhs.ca.gov/pcfh/cms/HTML/HRIF.htm	• Newborns, typically NICU graduates who are at increased risk for developmental disabilities	• Visits occur weekly, decreasing to biweekly, monthly and quarterly, • Services provided through age 2 • Caseload 20-25 families per home visitor depending on acuity	Bachelors Degree in the area of nursing, psychology child development, and related fields
Nurse-Family Partnership • Improve pregnancy outcomes • Improve child health and development • Improve families economic self-sufficiency There are currently nine replication sites in California. www.nccfc.org	• Low-income, first-time mothers • Voluntary enrollment	• Services begin prenatally • Visits occur weekly fading to monthly • Services provided through 2nd birthday • Caseload: 25 families	Bachelors Degree in nursing

XIII. Appendix D: Funding Streams for Home Visiting Programs in California

Home Visiting Program	Funding Stream
Adolescent Family Life Program (AFLP)	• Federal Title V, Maternal and Child Health (MCH) Block Grant • California MCH Branch awards funds to local community service providers and health departments.
Black Infant Health Program	• Federal Title V, MCH Block Grant • California MCH Branch awards funds to local community service providers and health departments.
California Safe and Healthy Families (Cal-SAHF)	• California Department of Social Services, Office of Child Abuse Prevention • Office of Criminal Justice and Planning, Answers Befitting Children (ABC) grants
Cal-Learn	• Personal Responsibility and Work Opportunity Reconciliation Act of 1996 administered by Department of Health and Human Services • California Work Opportunity and Responsibility to Kids (CalWORKs) Program, administered by Department of Social Services. • Funds allocated to County social service agencies who contract out to local AFLP providers
Child Abuse Prevention Intervention and Treatment (CAPIT) Program	Funding is derived from three state legislative initiatives. • AB 1733 authorizes state funding for child abuse prevention and intervention services. • AB 2994 establishes a County Children's Trust Fund which requires that $4 of any $7 fee for a certified copy of a birth certificate shall be paid for prevention services. • SB750 enables counties to add $3 to this surcharge. • Administered by the California Department of Social Services
Early Head Start	• Department of Health and Human Services, Administration for Children and Families (ACF) • Grants are awarded by ACF Regional Offices to local public and private grantee organizations. Some grantees subcontract to delegate agencies.
Early Start	• The Federal Early Intervention Program for Infants and Toddlers with Disabilities was enacted in 1986 under the Individuals with Disabilities Education Act. • State legislature passed the California Early Intervention Services Act in 1993. Administered by the California Department of Developmental Services and California Department of Education
Family Preservation	• Federal Omnibus Budget Reconciliation Act of 1993 provided new funds under Title IV-B, the Child and Family Services Program of the Social Security Act. • State legislation, AB 546 allows counties to use part of their child welfare funding for programs which prevent or limit unnecessary placement. • California Department of Social Services • County Department of Children and Family Services, and the Department of Mental Health

Home Visiting Program	Funding Stream
Head Start Home-Based Option	• Department of Health and Human Services, Administration for Children and Families (ACF) • Grants are awarded by ACF Regional Offices to local public and private grantee organizations. Some grantees subcontract to delegate agencies.

XIV. Appendix E: Federal Funding Sources for Home Visiting Programs

Excerpts from: Marshall, E., Nurse Home Visitation Program: Guide to Identifying Federal Funding Resourced for Program Implementation. 2000, National Center for Children, Families, and Communities and Replication & Program Strategies, Inc.: Philadelphia. p. 37.

Medicaid

Title XIX of the Social Security Act, commonly known as Medicaid, allocates federal matching funds to states providing medical services to certain groups of needy low income families, pregnant women, children and the elderly. Medicaid is managed at the Federal level by the Health Care Financing Administration (HCFA), a division of the Department of Health and Human Services (DHHS).

The federal government sets broad parameters and policies regarding the design and administration of Medicaid. Operating within these guidelines, states ultimately decide who is eligible, what services will be covered and who may provide covered services. Medicaid provides coverage to those classified as "categorically needy" or more liberally classified as "categorically related."

As of August 2000, the National Center for Children, Families and Communities report found that 13 of 28 states that had implemented the Nurse Home Visiting model were tapping into Medicaid to fund all or part of their programs. Sites are accessing Medicaid in two different ways. The most prevalent is through the option states have under federal Medicaid rules to amend their state plans to provide what is often called targeted case management. The other, used less often, is through provisions in federal law that allow HCFA to waive various requirements so that statesmay provide other kinds of services.

The advantage of Medicaid is that it has the potential to be an ongoing source of support. However, securing Medicaid funding can be complicated and time-consuming. States recognize that allowing coverage of a new service may commit them to pay for that service in the long-run, and thus, tend to exercise extra scrutiny in these situations.

Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) (Public Law 104-193), was established by the Personal Responsibilities and Work Opportunity Reconciliation Act of 1996 (PRWORA), which was signed into law August 22, 1996. TANF is a block grant program intended to move welfare recipients into the workforce and make welfare a program of temporary assistance.

States decide the services or benefits that are to be provided by their TANF programs as well as the eligibility requirements. States must use all of their federal TANF funds for services that lead to the achievement of the following four purposes outlined in the federal TANF statute:

- Provide assistance to needy families so that children may be cared for in their homes or in the homes of relatives;

- End needy parents' dependence on government benefits by promoting job preparation, employment and marriage;
- Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
- Encourage the formation and maintenance of two-parent families.

The NCCFC report found that TANF offers nurse home visiting sites funding that can legitimately support a greater portion of nurse home visiting program's non-medical services than Medicaid. While TANF funds cannot be used to support health care services per se, it is intended to support all manner of services that can reasonably be said to stabilize and strengthen families, prevent or reduce placing children in foster care, and prevent or reduce out-of-wedlock pregnancies. For this reason, TANF is second only to Medicaid in terms of being the most accessed source of funding among nurse home visiting programs.

XV. Appendix F: Summary of the Packard Foundation Report

The Spring/Summer 1999 issue of *The Future of Children*, published by the David and Lucile Packard Foundation, provides detailed program descriptions of six national home visiting programs and their evaluations. Below are excerpts from the report followed by a summary of the key evaluation findings. [3]

Summary description of programs in the Packard Foundation report:

- The Nurse Home Visitation Program (recently named the Nurse-Family Partnership) was developed by Dr. David Olds and is a two-year nurse visiting program targeting low-income first-time mothers. NHVP aims to improve pregnancy outcomes, child health and development, and maternal life course.
- Hawaii's Healthy Start Program is a five-year program employing primarily paraprofessionals and those with bachelor's degrees as home visitors. The program targets parents of newborns in Hawaii who were identified as being at risk for abuse and neglect. It aims to optimize child development, parenting skills, utilization of a medical home, and prevent child abuse.
- Parents as Teachers (PAT) is a three-year program using paraprofessionals and degreed visitors. The program targets families with young children typically up to age 3, and aims to prepare children for school, empower parents to achieve parenting skills, and to prevent and reduce child abuse.
- Home Instruction Program for Preschool Youngster (HIPPY) is a two-year program using paraprofessionals. The program targets families with preschool - kindergarten-aged children, and aims to empower parents as primary educators and help children prepare for school.
- Comprehensive Child Development Program (CCDP) is a five-year program that uses paraprofessionals and those with associate degrees. The program targets low-income families with young children, and aims to enhance the physical and psychosocial development of children, support parents, and assist families in becoming economically self-sufficient.
- Healthy Families America (HFA) is a five-year program that is based on the Hawaii Healthy Start Program and similarly uses paraprofessionals and those with bachelor's degrees. The program targets parents who were identified as at risk for child abuse, and aims to promote positive parenting and prevent child abuse and neglect.

Excerpts from "Home Visiting: Recent Program Evaluations - Analysis and Recommendations" pp. 4-26 [3]

Note: The report's analysis and recommendations were based on the most methodologically rigorous studies of the six major program models, and not on all the evaluations ever done of these programs.

- Parenting Skills: Several programs found benefits in this area, but typically on self-report scales rather than in observed parent-child interactions. Results suggest that these programs may lead parents to change some of the precursor attitudes, though not necessarily the behaviors that are related to child development or the prevention of abuse.
- Utilization of Preventive Health Services: None of the evaluations found benefits in immunization rates or the number of well-child visits. The Hawaii Healthy Start Program did

find that more home-visited than control group families reported having a regular medical provider.

- Birth Outcomes: Of the six programs, only the NHVP measured preterm births and birth weights. Of the two studied sites for the NHVP model, only one showed reductions in preterm births and percentage of low-birthweight babies, but these improvements were only found for very young teens and smokers.
- Child Development: A few statistically significant findings occurred with the two programs in which children's development was a primary focus - HIPPY and PAT. Results were mixed between study cohorts and study sites, and were relatively small in size. Children born to Latina mothers participating in one site of the PAT program showed improvement on measures of cognitive, linguistic, and social development, and self-help behavior.
- Children's Behavior: Only the NHVP Elmira study and the CCDP assessed children's behavior, and only the NHVP Elmira study assessed behavior more than a few years after the end of the program. In a 15-year follow-up of children in Elmira, no improvements were found for school suspensions, initiation of sexual intercourse, and various anti-social acts and behavioral problems. However, Elmira did show fewer instances of running away, arrests, and convictions, fewer cigarettes smoked per day, fewer days having consumed alcohol, and less lifetime promiscuity.
- Child Abuse and Neglect: Study findings may be limited due to the difficulty in accurately measuring child abuse. The clearest evidence that home visiting can prevent child abuse comes from the Elmira study of NHVP in which long-term follow-up of families indicated children in the intervention group had fewer substantiated child abuse reports over the course of the first 15 years of the children's lives. The families that showed the most benefit were those who had the least sense of control. In a PAT program for teen parents, the teens that received both PAT home visiting and case management services showed improvement, but the groups that received only PAT home visiting or only case management services did not. The Hawaii Healthy Start Program and the HFA found no improvements in child abuse and neglect, but they did show improvements in the mother's self-reported use of harsh discipline and on scales associated with risk for abuse.
- Maternal Life Course: Although altering maternal life course was not an explicit goal for most of these programs, all of the evaluations (except HIPPY's) measured outcomes such as maternal employment, completion of school, or deferral of subsequent births. Only NHVP found benefits in these areas, and only for poor unmarried (largely teen) women.

XVI. Appendix G: Examples of Home Visiting Program Performance Measures

	QUANTITY	QUALITY
INPUT OR EFFORT	**Quadrant I – How much did we do?** ▪ # of clients enrolled ▪ # of clients who declined participation ▪ # of referrals received ▪ # of visits completed ▪ # of home visitors recruited to provide services ▪ # of client recruitment outreach presentations ▪ # of clients graduating from (completing) program	**Quadrant II – How well did we do it?** ▪ Average caseload per home visitor ▪ Ratio of clients accepting vs. declining participation ▪ Ratio of completed vs. expected visits ▪ % of home visitors recruited and remaining in project ▪ Rate of client attrition
OUTPUT OR EFFECT	**Quadrant III – Is anyone better off?** ▪ # of infants with normal birth weight ▪ # of adult clients earning a living wage ▪ # of minor clients enrolled in school or General Educational Development (GED) Diploma ▪ # of clients who reduce smoking ▪ # of clients with referrals for child abuse reports ▪ # of clients delaying subsequent pregnancies while enrolled in project ▪ Average standardized score (using the Peabody Picture Vocabulary Test) measuring cognitive development of child at age 3	**Quadrant IV – What percent are better off?** ▪ % of infants with normal birth weight ▪ % of adult earning a living wage ▪ % of minor clients enrolled in school or GED ▪ % of clients who reduce smoking ▪ % of clients with referrals for child abuse reports ▪ % of clients delaying subsequent pregnancies while enrolled in project ▪ % of clients fully immunized at age 2

XVII. Appendix H: Fresno County's Nurse-Family Partnership Program

Fresno County is one of nine California sites implementing the Nurse-Family Partnership (NFP) Program. (For a complete list of all sites, see the table at the end of this Appendix). NFP programs are replication sites for the Nurse Home Visitation Program (NHVP) developed by Dr. David Olds and are supported through training, technical assistance, and data management and analysis by the National Center for Children, Families, and Communities at the University of Colorado.

The goals of Fresno County's NFP Program are to:

1. Improve pregnancy outcomes by helping women improve their health-related behaviors, including reducing use of cigarettes, alcohol, and illegal drugs;
2. Improve child health and development by helping parents provide more responsible and competent care for their children; and
3. Improve families' economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

The target population of the NFP program is first-time mothers who reside in Fresno County. The county has an extensive outreach program that receives referrals from the Department of Employment and Temporary Assistance, doctors' offices, school nurses, and door-to-door outreach in high-risk areas. All first-time mothers at less than a 28 weeks' gestation are referred to the NFP Program. Women who are pregnant but don't meet the NFP eligibility criteria are referred to other home visiting programs in the county such as Black Infant Health, Babies First (Healthy Start), Comprehensive Case Management Program for high-risk women, Public Health Nursing, Cal-LEARN, or the Adolescent Family Life Program.

While it is important to follow the planned schedule of visits, adjustments are made based on the family's own situation. The visits last about 1 to 1 ½ hours. The nurse's responsibilities during the visit are to listen to the client's needs and concerns, provide information and resources, and assist the client in setting and meeting health and life goals. The client's responsibilities are to be open to information, apply what makes sense, set their own goals, and carry out plans to meet those goals.

Fresno County's NFP program is 100% funded by the county, and its nurse home visitors must have a baccalaureate nursing degree. Other qualifications such as prior experience working with maternal/child populations, strong interpersonal skills, and sensitivity to the values and beliefs of differing racial and ethnic communities are helpful. An experienced nurse home visitor will follow 25 clients, and nurses who are new to the program will follow 20 clients for the first year. This allows the nurse to become proficient in the model and familiar with available county services.

One of the most important roles that the nurse home visitors play is to help families identify their needs and then gain access to the community resources that can meet those needs. The nurse's main focus is on the mother, but she also works with the father and other members in the household. During home visits, the nurse focuses on the following six domains: 1) personal health; 2) environmental health; 3) life-course development; 4) maternal role; 5) family and friends; and 6) health and human services.

The needs of the client set the priority for what is covered at each visit. Each nurse is given a mixed caseload of demanding and less demanding cases. The nurse fashions the program around the client; the mother's personal and social support resources determine the specific components.

Nurses are trained in Nursing Child Assessment Satellite Training (NCAST). The program teaches them how to evaluate the interaction between child, environment, and mother. The nurse is trained in infant states and teaches parents how and when to interact with the baby. By helping parents learn baby cues – engagement cues (when baby wants to be with you) and disengagement cues (when baby is telling you he/she needs a break) – parents can then help guide more satisfactory interactions with their children. Training is also provided in the Partners in Parent Education (PIPE). The PIPE topic areas are: 1) Listen, listen, listen; 2) Love is layers of sharing; and 3) Playing is learning.

Fresno has two added components to the program. The first is a mental health component provided by a licensed mental health clinician who works with the nurses to assist the clients if they have any mental health issues. She also makes home visits if the client agrees to services. The second added component is a support group called "Mommy and Me Play Group" that aims to prevent the depression and isolation experienced by many first-time mothers. The group encourages mothers to implement the skills gained during their PIPE training that they receive from nurses during the course of their home visits. Other topics that are covered are parenting issues and English as a second language. The support group also organizes educational outings for mothers that increase their knowledge of local resources. First-time mothers in the program support each other as they become more empowered through solving parenting problems, breastfeeding, nutrition, and violence issues.

A well-tested and maintained record-keeping and clinical information system has proven to be both clinically and administratively useful in the successful operation of the program. In order to monitor performance, specific information is collected at each home visit by completing data forms. These data forms, which cover maternal/infant health assessments, health habits, demographics, parenting issues, and personal beliefs, help the developers of the program at the National Center in Colorado provide useful feedback and technical assistance as implementation proceeds. Furthermore, the record keeping system helps to assure that families are receiving comprehensive assessments and education services by the nurse home visitors as well as referrals to services available in their community.

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Nurse-Family Partnership Program – California Sites

Site Location & Initial Training Date	Contact Person	Phone Number	Email Address
Fresno, CA Jan. 1998*	Connie Woodman Carol Turk-Henry (S)	559-445-3307 559-445-3542	cwoodman@fresno.ca.gov cturk@fresno.ca.gov
Kern County, CA (Bakersfield) Jan. 2001	Cindy Wasson	661-868-0400	wassonc@co.kern.ca.us
Los Angeles, CA Jan. 1998*	Jeanne Smart Cindy Chow (S)	213-240-8192 213-240-8425	jsmart@dhs.co.la.ca.us cchow@dhs.co.la.ca.us
Monterey, CA Jan. 1999	Linda Wolleson (S)	831-755-4611	wollesenl@co.monterey.ca.us
Orange County, CA Jan. 1999	Kathleen Parris Pat Place (S)	714-834-8150 714-834-8218	kparris@hca.co.orange.ca.us pplace@hca.co.orange.ca.us
Riverside, CA Oct. 2000	Judy Halstead Earp Barbara Livak (S)	909-358-5516 909-358-5006	jearp@co.riverside.ca.us blivak@co.riverside.ca.us
Sacramento, CA Mar.2001	Bernice Walton	916-875-5471	waltonb@dhhs.co.sacramento.ca.us
San Diego, CA Oct. 1999	Rose Fox Gaby Kuperman (S)	619-409-3303 619-668-3641	rfoxxxhe@co.san-diego.ca.us gkuperhe@co.san-diego.ca.us
Santa Clara, CA Jan. 1999	Sandie Couser Laura Brunetto (S)	408-299-4305 408-299-4305	sandie.couser@hhs.co.santa-clara.ca.us laura.brunetto@hhs.co.santa-clara.ca.us

(S) Denotes the nurse supervisor for the program

(*) Part of initial Weed and Seed Initiative

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XVIII. Appendix I: The Hope Street Family Center Home Visitation Program

Desired Results

The Hope Street Family Center home visitation program is part of a national effort to promote the overall health, social, emotional, cognitive, and physical development of children, 0 to5 years of age, while simultaneously enhancing family self-sufficiency and the capacity of families to nurture and care for their young children.

Context of Home Visiting Services

The Hope Street Family Center was established in 1992, as a collaboration between the University of California, Los Angeles and California Hospital Medical Center. Located on the campus of the California Hospital Medical Center, Hope Street is a family resource center that integrates home visitation with comprehensive center-based early childhood education, parenting, adult education, family literacy, and child care services.

Target Population

The target population for home visitation services includes pregnant women, infants, toddlers, and pre-school-aged children who meet federal low-income guidelines and live within the service area of central Los Angeles.

The Hope Street Family Center targets a population of nearly 500,000 residents, one-third of whom are under 17 years of age, with 10% four years of age or younger. Seventy-seven percent of the population is Latino; 9% African-American; 7% Asian; and 6% Caucasian. Thirty-eight percent of households have incomes of less than $15,000. Nearly 40% of youth 0-17 years of age have no health insurance. Downtown Los Angeles is ranked as the highest low-literacy area in the county.

Intensity of Home Visits

The home visitation model employed by Hope Street uses a combination in-home and center-based design that is flexible, fluid, and responsive to the changing circumstances of individual families. Home visitation options include (a) weekly home visits, approximately 90 minutes in duration; (b) weekly or biweekly home visits coupled with center-based activities for parents and children, one to five times per week; and (c) weekly or bi-weekly home visits concurrent with daily center-based early childhood education services for children, 0-5 years of age. These various options offer parents choices as family needs and circumstances change over time. For example, a family may participate in home visitation services only during the prenatal period or immediately after the child's birth. When the child is older or as parents return to work or school, the family may opt to participate in a combination of center- and home-based services.

Home visitation services are provided within an ecologic framework that considers the needs of the child as well as the needs and resources of the child's family and community. Services are designed

to be comprehensive, continuous, and family-focused. They typically begin prenatally and extend through the child's fifth year of life.

Caseloads

Home visit caseloads average 10-12 families per home visitor.

Service Array

Home visitation activities typically fall into the broad categories of early childhood education, parenting education, health education and anticipatory guidance, and case management/family support services.

Center-based services include a family literacy program; English as a Second Language (ESL) classes; continuation high school coursework leading to a high school diploma; parenting education classes; infant, toddler and preschool early childhood education classes; full-day childcare; and Mommie and Me or Daddy and Me playgroups. Additional center-based services include monthly Dads and Kids outings, family field trips, camping opportunities for parents and children, and a program of structured after-school mentoring and recreational activities for school-aged siblings.

Staff Qualifications

Qualities and characteristics used to guide staff hiring include: (a) linguistic and cultural competence, (b) an understanding of how to serve young children within the context of their family, (c) experience in providing home-based services, and (d) a willingness to acquire new skills and expand one's area of expertise. Home visitors are required to have a minimum of a bachelor's degree in the areas of early childhood education, social work, psychology, nursing, or a related field. The program also utilizes a supervisory team with master's degrees in psychology, social work, earlychildhood education, and nursing. This mix of backgrounds and areas of clinical expertise encourages staff to employ multidisciplinary approaches in planning, developing, and implementing home visitation services.

Standardized Curriculum

The home visitation program utilizes a locally developed curriculum that draws heavily upon the Partners in Parenting (PIPE) and Creative Curriculum (Trister-Dodge). The content of the home visit is the result of weekly planning between the parent and the home visitor and is based upon an assessment of family interests, needs, and strengths in the areas of health and nutrition, child development and parenting, education and training, family relationships and community supports, and the physical home environment.

The extent to which the program model is implemented and the extent to which parents and children are participating in program services is monitored through regular review of MIS data and reports, weekly case conferences, monthly chart audits, weekly individual supervision and case discussions, and regular joint home visits.

Special Outreach

Many of the fathers in the families who receive home visitation services are working and unable to participate in home visits conducted during the day. Through the Daddy and Me playgroups and the Dads and Kids Saturday activities, the program makes a special effort to ensure that fathers have opportunities to spend time with their young children, in ways that strengthen the development of healthy, positive relationships.

Educational, health care, and recreational services are also offered for school-aged siblings and for the "graduates" of the early childhood home visitation program. These services support the foundation for school readiness that was laid down during the pre-school years and help insure children's continued academic success.

Program Evaluation and Continuous Quality Improvement

The Hope Street Family Center's evaluation and continuous quality improvement plans utilizes information gathered from MIS statistics, community assessment data, parent surveys and focus group interviews, staff surveys and focus group interviews, community focus group interviews, observational assessments, and clinical case reviews and chart audits as the basis for short and long-term program evaluation, development and planning activities. Extensive program and fiscal audits are conducted on an annual basis by an independent evaluation consultant and at least every 3 years by a monitoring team representing the principal funding agency.

Integration and Coordinating Funding

The Hope Street Family Center is supported by funds from the U.S. Department of Health and Human Services, Head Start Bureau; California Department of Education; City of Los Angeles; Los Angeles County Children and Families First, Proposition 10 Commission; California Hospital Medical Center Foundation; UniHealth Foundation; Catholic Healthcare West Southern California; and a variety of private donors and foundations.

Linkages with the Service System

The Hope Street Family Center is active in a broad array of community collaboratives and service provider networks. In addition, the Center has entered into formal partnerships that include shared resources (facilities, staff, and finances) with the Los Angeles Unified School District, Los Angeles County Department of Health Services, and four community based agencies.

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XIX. Appendix J: The Alameda County Children and Families Commission Every Child Counts Initiative

One of the core strategies of the Alameda County Children and Families Commission's *Every Child Counts* (ECC) initiative is to provide family-support services which concentrate on five core areas: prenatal services, home visits after birth, intensive family support, infant mental health, and school readiness. The ECC has a two-pronged approach to providing home visiting services to families with young children under the Family Support Services initiative (refer to the website ackids.org for more details).

First, the "universal" strategy provides one to three home visits to all newborns through age three regardless of income or psychosocial risk factors. Second, targeted and intensive family support services focus on at-risk families. The ECC's family support approach employs empirically validated best practices and employs a family-centered, relationship-based framework.

The "universal" home visiting component is currently being phased-in at three of the 11 local hospitals. Hospital Outreach Coordinators (HOCs) greet mothers, their newborns and families in the hospitals and explain the home visiting program. HOCs receive written consent from the mothers in the hospitals to participate and share program information, and they also enroll families into the program as appropriate.

Once clients are enrolled into the program, HOCs make electronic referrals to the designated contractors for the provision of home visiting services. Project contractors are Alameda County Public Health Nurses (PHNs), the City of Berkeley PHNs, and a community-based organization in the City of Alameda.

PHNs conduct the first home visit within 48-72 hours of the initial referral, and provide up to three home visits per client. The home visiting model is relationship-based with specific protocols and curriculum designed to cover key domains, as they are relevant to the mother and family's life-course development. If clients are found to have greater needs, the "Plus 10" program makes an additional 10 home visits available to the family with added protocols including a maternal mental health assessment.

The second component of the Family Support Services' home visiting strategy is to target intensive family support services for children who are medically fragile, parents who are teenagers, and families with referrals due to child protection. Special Start is a joint project of Children's Hospital Oakland and the Alameda County Public Health Department. Children's Hospital follows the medically fragile infants and PHNs from the Special Start unit of the county follow the babies born who are determined to be at high social risk. With grants from *Every Child Counts*, the East Bay Perinatal Council and Tiburcio Vasquez Health Center, who provide services to teen mothers, have expanded their Cal-LEARN and Adolescent Family Life Programs to provide more extensive family support services. Clients receiving intensive family support services can be followed up to the child's fifth birthday as necessary. For both the "universal" and intensive family support services components, multi-disciplinary teams are available for consultation including developmental, substance abuse, and infant mental health specialists.

As of March 2001, 1268 families had been offered family support services, and of those 1217 (96%) enrolled in the "universal" one to three home visiting component. Of those enrolling, 1144 (94%) signed consent forms and 146 (12%) went on to be offered the Plus 10 home visits program. Under the intensive family support component, Children's Hospital Oakland and Public Health Nursing from July to December 2000 provided home visiting services to 218 medically fragile babies and their families through the Special Start Program.

The Alameda County, Children and Families Commission's *Every Child Counts* (ECC) home visiting initiative is very ambitious and exciting. It is unique in California, as it aims to provide both universal and targeted home visiting services that are based on the best-practices of various proven effective models. With approximately 20,000 new births in Alameda County each year, this home visiting initiative can potentially have a significant impact on the well-being of young children and their families in the county.

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